Enclosure 4

Attachment 4.19 D

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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Plan # 98-03
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37.40.301 SCOPE, APPLICABILITY AND PURPOSE (1) This subchapter specifies requirements applicable to provision of and reimbursement for medicaid nursing facility services, including intermediate care facility services for the mentally retarded. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) These rules are subject to the provisions of any conflicting federal statute, regulation or policy, whether now in existence or hereafter enacted or adopted.

(3) Unless otherwise provided in these rules, this subchapter applies to rate years beginning on or after July 1, 1991. Reimbursement and other substantive nursing facility requirements for earlier periods are subject to the laws, regulations, rules and policies then in effect. Procedural and other non-substantive provisions of these rules are effective upon adoption. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

37.40.302 DEFINITIONS Unless the context requires otherwise, in this subchapter, the following definitions apply:

(1) "Abstracts" mean patient assessment abstracts submitted by providers to the department in accordance with the rules in effect for state fiscal year 1999.

(2) "Administrator" means the person licensed by the state, including an owner, salaried employee, or other provider, with daily responsibility for operation of the facility. In the case of a facility with a central management group, the administrator, for the purpose of these rules, may be a person other than the titled administrator of the facility if such person has daily responsibility for operation of the nursing facility and is currently licensed by the state as a nursing home administrator.

(3) "Case mix index (CMI)" means an assigned weight or numeric score assigned to each RUG-III grouping which reflects the relative resources predicted to provide care to nursing facility residents.

(4) "Department" means the Montana department of public health and human services or its agents, including but not limited to parties under contract to perform audit services, claim processing and utilization review.

(5) "Department audit staff" and "audit staff" mean personnel directly employed by the department or any of the department's contracted audit personnel or organizations.

(6) "Estimated economic life" means the estimated remaining period during which property is expected to be economically usable by

one or more users, with normal repairs and maintenance, for the purpose for which it was intended when built.

(7) "Extensive remodeling" means a renovation or refurbishing of all or part of a provider's physical facility, in accordance with certificate of need requirements, when the project's total cost depreciable under generally acceptable accounting principles exceeds, in a 12 month period, $2,400 times the number of total licensed nursing facility beds in the facility. "Extensive remodeling" does not include the construction of additional new beds, but may include construction of additional square feet or conversion of existing hospital beds to nursing facility beds if the cost requirements of this definition are met.

(8) "Fiscal year" and "fiscal reporting period" both mean the provider's internal revenue tax year.

(9) "Licensed to non-licensed ratio" means the ratio computed when the sum of all hourly registered and licensed practical nurse wages, paid or accrued by all providers, divided by the total number of registered and licensed practical nurse hours, is divided by the sum of all hourly nurse aide wages, paid or accrued by all providers divided by the total number of nurse aide hours.

(a) The licensed to non-licensed ratio will be computed using information from the most recent cost report on file as of April 1 immediately prior to the rate year, or if the hourly component of such information is not available from the cost report, from the staffing reports filed pursuant to ARM 37.40.315 for the period corresponding to the cost report period from which wage information is used to set the ratio. If the necessary information for a particular facility is not available from a cost report and/or staffing report, the wages, benefits and hours from that facility will not be used to set the ratio.

(10) "Maintenance therapy and rehabilitation services" mean repetitive services required to maintain functions which do not involve complex and sophisticated therapy procedures or the judgment and skill of a qualified therapist and without the expectation of significant progress.

(11) "Medicaid recipient" means a person who is eligible and receiving assistance under Title XIX of the Social Security Act for nursing facility services.

(12) "Minimum data set (MDS)" means the assessment form approved by the health care financing administration (HCFA), and designated by the department to satisfy conditions of participation in the medicaid and medicare programs.

(13) "Minimum data set RUG-III quarterly assessment form" means the three page quarterly, optional version for RUG-III 1997 update.

(14) "Nonemergency routine transportation" means transportation for routine activities, such as outings scheduled by the facility, nonemergency visits to physicians, dentists, optometrists or other

medical providers. This definition includes such transportation when it is provided within 20 miles of the facility.

(15) "Nursing facility services" means nursing facility services provided in accordance with 42 CFR, part 483, subpart B, or intermediate care facility services for the mentally retarded provided in accordance with 42 CFR, part 483, subpart I. The department hereby adopts and incorporates herein by reference 42 CFR, part 483, subparts B and I, which define the participation requirements for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) providers, copies of which may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. The term "nursing facility services" includes the term "long term care facility services". Nursing facility services include, but are not limited to, a medically necessary room, dietary services including dietary supplements used for tube feeding or oral feeding such as high nitrogen diet, nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Payment for the services listed in this subsection is included in the per diem rate determined by the department under ARM 37.40.307 or 37.40.336 and no additional reimbursement is provided for such services. Nursing facility services include but are not limited to the following or any similar items:

(a) all general nursing services, including but not limited to administration of oxygen and medications, handfeeding, incontinence care, tray service, nursing rehabilitation services, enemas, and routine pressure sore/decubitis treatment;

(b) services necessary to provide for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life;

(c) services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each medicaid recipient who is a resident in the facility;

(d) items furnished routinely to all residents without charge, such as resident gowns, water pitchers, basins and bed pans;

(e) items routinely provided to residents including but not limited to:

(i) anti-bacterial/bacteriostatic solutions, including betadine, hydrogen peroxide, 70% alcohol, merthiolate, zepherin solution;

(ii) cotton;

(iii) denture cups;

(iv) deodorizers (room-type);

(v) distilled water;

(vi) enema equipment and/or solutions;

(vii) facial tissues and paper toweling;

(viii) finger cots;

(ix) first aid supplies;

(x) foot soaks;
(xi) gloves (sterile and unsterile);
(xii) hot water bottles;
(xiii) hypodermic needles (disposable and non-disposable);
(xiv) ice bags;
(xv) incontinence pads;
(xvi) linens for bed and bathing;
(xvii) lotions (for general skin care);
(xviii) medication - dispensing cups and envelopes;
(xix) ointments for general protective skin care;
(xx) ointments (anti-bacterial);
(xxi) personal hygiene items and services, including but not limited to:
(A) bathing items and services, including but not limited to towels, washcloths and soap;
(B) hair care and hygiene items, including but not limited to shampoo, brush and comb;
(C) incontinence care and supplies appropriate for the resident's individual medical needs;
(D) miscellaneous items and services, including but not limited to cotton balls and swabs, deodorant, hospital gowns, sanitary napkins and related supplies, and tissues;
(E) nail care and hygiene items;
(F) shaving items, including but not limited to razors and shaving creme;
(G) skin care and hygiene items, including but not limited to bath soap, moisturing lotion, and disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection; and
(H) tooth and denture care items and services, including but not limited to toothpaste, toothbrush, floss, denture cleaner and adhesive;
(xxii) safety pins;
(xxiii) sterile water and normal saline for irrigating;
(xxiv) sheepskins and other fleece-type pads;
(xxv) soaps (hand or bacteriostatic);
(xxvi) supplies necessary to maintain infection control, including those required for isolation-type services;
(xxvii) surgical dressings;
(xxviii) surgical tape;
(xxix) over-the-counter drugs (or their equivalents), including but not limited to:
(A) acetaminophen (regular and extra-strength);
(B) aspirin (regular and extra-strength);
(C) cough syrups;

(D) specific therapeutic classes D4B (antacids), D6S (laxatives and cathartics) and Q3S (laxatives, local/rectal) including but not limited to:

(I) milk of magnesia;
(II) mineral oil;
(III) suppositories for evacuation (dulcolax and glycerine);
(IV) maalox; and
(V) mylanta;
(E) nasal decongestants and antihistamines;
(xxx) straw/tubes for drinking;
(xxxi) suture removal kits;
(xxxii) swabs (including alcohol swab);
(xxxiii) syringes (disposable or non-disposable hypodermic; insulin; irrigating);
(xxxiv) thermometers, clinical;
(xxxv) tongue blades;
(xxxvi) water pitchers;
(xxxvii) waste bags;
(xxxviii) wound-cleansing beads or paste;
(f) items used by individual residents which are reusable and expected to be available, including but not limited to:
(i) bathtub accessories (seat, stool, rail);
(ii) beds, mattresses, and bedside furniture;
(iii) bedboards, foot boards, cradles;
(iv) bedside equipment, including bedpans, urinals, emesis basins, water pitchers, serving trays;
(v) bedside safety rails;
(vi) blood-glucose testing equipment;
(vii) blood pressure equipment, including stethoscope;
(viii) canes, crutches;
(ix) cervical collars;
(x) commode chairs;
(xi) enteral feeding pumps;
(xii) geriatric chairs;
(xiii) heat lamps, including infrared lamps;
(xiv) humidifiers;
(xv) isolation cart;
(xvi) IV poles;
(xvii) mattress (foam-type and water);
(xviii) patient lift apparatus;
(xix) physical examination equipment;
(xx) postural drainage board;
(xxi) room (private or double occupancy as provided in ARM 37.40.331);
(xxii) raised toilet seat;
(xxiii) sitz baths;
(xxiv) suction machines;

(xxv) tourniquets;
(xxvi) traction equipment;
(xxvii) trapeze bars;
(xxviii) vaporizers, steam-type;
(xxix) walkers (regular and wheeled);
(xxx) wheelchairs (standard);
(xxxi) whirlpool bath;

(g) laundry services whether provided by the facility or by a hired firm, except for residents' personal clothing which is dry cleaned outside of the facility; and

(h) nonemergency routine transportation as defined in (14).

(16) "Patient contribution" means the total of all of a resident's income from any source available to pay the cost of care, less the resident's personal needs allowance. The patient contribution includes a resident's incurment determined in accordance with applicable eligibility rules.

(17) "Patient day" means a whole 24-hour period that a person is present and receiving nursing facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, such day will be considered a patient day. When department rules provide for the reservation of a bed for a resident who takes a temporary leave from a provider to be hospitalized or make a home visit, such whole 24-hour periods of absence will be considered patient days.

(18) "Provider" means any person, agency, corporation, partnership or other entity that, under a written agreement with the department, furnishes nursing facility services to medicaid recipients.

(19) "Rate year" means a 12-month period beginning July 1. For example, rate year 1995 means a period corresponding to the state fiscal year July 1, 1994 through June 30, 1995.

(20) "Resident" means a person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

(21) "RUG-III" means resource utilization group, version III.

(22) "RUG-III grouper version" means the resource utilization group version III algorithm that classifies residents based upon diagnosis, services provided and functional status using MDS assessment information for each resident.

(23) "Total allowable remodeling costs" means those remodeling costs which are supported by adequate documentation. These costs include, but are not limited to, all costs of construction. These costs do not include costs of moveable equipment, supplies, furniture, appliances or other similar items. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93, (14)(e) Eff. 10/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff.

7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 76, Eff. 1/17/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.306 PROVIDER PARTICIPATION AND TERMINATION REQUIREMENTS (1) Nursing facility service providers, as a condition of participation in the Montana medicaid program must meet the following requirements:

(a) comply with and agree to be bound by all laws, rules, regulations and policies generally applicable to medicaid providers, including but not limited to the provisions of ARM 37.85.401, 37.85.402, 37.85.406, 37.85.407, 37.85.410, 37.85.414, and 37.85.415;

(b) maintain a current license issued by the department of public health and human services under Montana law for the category and level of care being provided, or, if the facility is located outside the state of Montana, maintain a current license under the laws of the state in which the facility is located for the category and level of nursing facility care being provided;

(c) maintain a current certification for Montana medicaid issued by the department of public health and human services under applicable state and federal laws, rules, regulations and policies for the category and level of care being provided, or, if the facility is located outside the state of Montana, maintain current medicaid certification in the state in which the facility is located for the category and level of nursing facility care being provided;

(d) maintain a current agreement with the department to provide the level of care for which payment is being made, or, if the facility is located outside the state of Montana, comply with the provisions of ARM 37.40.337;

(e) operate under the direction of a licensed nursing home administrator, or other qualified supervisor for the facility, as applicable laws, regulations, rules or policies may require;

(f) for providers maintaining resident trust accounts, insure that any funds maintained in such accounts are used only for those purposes for which the resident, legal guardian, or personal representative of the resident has given written authorization. The provider must maintain personal funds in excess of $50 in an interest bearing account and must credit all interest earned to the resident's account. Resident's personal funds in amounts up to $50 must be maintained in such a manner that the resident has convenient access to such funds within a reasonable time upon request. A provider may not borrow funds from such accounts or commingle resident and facility funds for any purpose;

(g) A provider holding personal funds of a deceased nursing facility resident who received medicaid benefits at any time shall,

within 30 days following the resident's death, pay those funds as provided by law and regulation.

(h) maintain admission policies which do not discriminate on the basis of diagnosis or handicap, and which meet the requirements of all federal and state laws prohibiting discrimination against the handicapped, including persons infected with acquired immunity deficiency syndrome/human immunodeficiency virus (AIDS/HIV);

(i) comply with ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120, 37.40.201 through 37.40.207 and 46.12.1101, regarding screening for nursing facility services;

(j) comply with all applicable federal and state laws, rules, regulations and policies regarding nursing facilities at the times and in the manner required therein, including but not limited to 42 USC 1396r(b)(5) and 1396r(c) (1994 supp.) and implementing regulations, which contain federal requirements relating to nursing home reform. The department hereby adopts and incorporates herein by reference 42 USC 1396r(b)(5) and 1396r(c). A copy of these statutes may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(2) A provider which fails to meet any of the requirements of this rule may be denied medicaid payments, refused further participation in the medicaid program or otherwise sanctioned or made subject to appropriate department action, according to applicable laws, rules, regulations or policies.

(a) Subject to applicable federal law and regulations, the department may impose a sanction or take other action against a provider that is not in compliance with federal medicaid participation requirements. Department sanctions or actions may include imposition of any remedy or combination of remedies provided by state or federal law and regulations, including but not limited to federal regulations at 42 CFR 488, subpart F.

(3) A provider must provide the department with 30 days advance written notice of termination of participation in the medicaid program. Notice will not be effective prior to 30 calendar days following actual receipt of the notice by the department. Notice must be mailed or delivered to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) For purposes of (3), termination includes a cessation of provision of services to medicaid residents, termination of the provider's business, a change in the entity administering or managing the facility or a change in provider as defined in ARM 37.40.325.

(b) In the event that discharge or transfer planning is necessary, the provider remains responsible to provide for such planning in an orderly fashion and to care for its residents until appropriate transfers or discharges are effected, even though transfer